ATTACHMENT D PART 4

SOUTHSIDE REGIONAL MEDICAL CTR
801 SOUTH ADAMS STREET
PETERSBURG, VA 23803

Name: WARD , MYRON A
Room: SOP -
MR#: 511619
Pat#: 6821654

DOB: 07/07/1970
Age: 33 Y
Sex: M

Exam: OPERATIVE REPORT
Adm Dr: RAYUDU, JUJJAVARAPU
Dict Dr: RAYUDU, JUJJAVARAPU
Transcribed: 05/20/2004 14:38:49
Dictated: 05/20/2004 13:09:04

*** Final ***

DATE OF OPERATION: 05/20/2004

PREOPERATIVE DIAGNOSIS: Cervical lymphadenopathy.

POSTOPERATIVE DIAGNOSIS: Cervical lymphadenopathy especially in the posterior triangle of the neck on the right side.

PROCEDURE PERFORMED: Lymph node biopsy from the posterior triangle of the right side of the neck.

SURGEON: JUJJAVARAPU RAYUDU, MD

ANESTHESIA: Local, 1% Lidocaine, 0.5% Marcaine, 1/2 and 1/2 combination prepared.

PLACE PERFORMED: Operating room.

HISTORY: This 33-year-old male presented with slightly enlarged lymph nodes along the posterior aspect of the neck, especially the right side. There is no evidence of any infection in the scalp or any areas of the head and neck. He is scheduled for a biopsy of this cervical lymph node.

PROCEDURE: The patient was placed supine on the table. The head was slightly elevated. Local anesthesia was infiltrated in the skin and subcutaneous tissues along the posterior aspect of the right side of the neck over the palpable lymph node. The transverse incision was given along this area. The platysmas muscle was incised along the line of the skin incision. The skin incision was made about 1-inch in length. After opening the platysmas muscle, the dissection was continued along the posterior aspect. The trapezius muscle was identified. It was careful preserved. There is a lymph node, which is visible and very close to this nerve. It is carefully preserved, and the lymph node is dissected from this structure carefully. The specimen was sent for histopathological examination. Hemostasis was completely secured. The platysmas was approximated with 4-0 Monocryl continuous suture. The skin was closed with 4-0 Monocryl subcuticular continuous suture. Dry foam dressing was applied. The patient tolerated the procedure well. Transferred to the recovery room in satisfactory condition.

81503179 / 96531

cc: DR ALLEN AT FCI LOW PRISON

Faxed 7-13-04 to Ms. Horikawa

5/26/04
M.D.

SOUTHSIDE REGIONAL MEDICAL CE

PATIENT NAME: Ward, Alyn

DATE: 5/12/04
HEIGHT: 5'10"
WEIGHT: 150 lbs

CONTINUING DNR: ☐ YES ☐ NO ☒ UNKNOWN
ADVANCED DIRECTIVE: ☐ YES ☐ NO ☒ UNKNOWN

IMMUNIZATIONS UP TO DATE: ☒ YES ☐ NO
Date of last Tetanus: 6/12/2000

VACCINES:
☐ INFLUENZA
☐ PNEUMOCOCCAL

Accompanied by:
Person giving information:
From (facility):

Mode of arrival: ☐ wheelchair ☐ stretcher ☒ ambulatory
Emergency Contact:
Name
Phone #

PATIENT COMPLAINT: lymphadenopathy neck area

HISTORY OF COMPLAINT: 33 y/o male with ? lumps in neck area x 1 yr

PHYSICAL FINDINGS: Bilat cervical lymphadenopathy, non-tender

Past Med HX
☐ Cardiac ☐ Cancer
☐ HTN ☐ Psych
☐ COPD ☐ Diabetes
☐ Asthma ☐ MI
☐ Seizures ☐ HIV
☐ CVA ☐ Hepatitis
☐ Renal

Surgeries:

PRIMARY LANGUAGE: ☒ English ☐ Other

INTERPRETER NEEDED? ☐ YES ☒ NO

PRELIMINARY SOCIAL Hx:
☐ Tobacco Use ☐ Alcohol Use ☐ Street Drugs

ALLERGIES/REACTION: No known drug allergy
LATEX ALLERGIES: ☐ YES ☒ NO

ROUTINE MEDICATION:
(including over the counter/herbal, natural remedies, vitamins, birth control pills)

Drug	Dose	Freq/Route	Last Dose	Compliant
Flagyl [illegible]		2 times/day		(Yes) / No
				Yes / No
				Yes / No
				Yes / No
				Yes / No
				Yes / No
				Yes / No
				Yes / No
				Yes / No

SKIN
☒ Normal ☐ Diaphoretic
☐ Dry ☐ Lotion/Aids
Describe Color, Turgor, Temp

☐ Surface Abnormalities

Oxygenation
Respiratory: ☒ No difficulty ☐ Pain ☐ Cough ☐ Dyspnea ☐ Sputum
☐ Tracheostomy
☐ Respiratory Equipment at Home ☐ No ☐ Yes
If yes, what?

Circulatory: ☒ No difficulty ☐ Edema ☐ Numbness
☐ Syncope ☐ Palpitations ☐ Murmur
☐ Pacemaker ☐ Chest pain ☐ Cyanosis

Comments:

No.7152 P. 4

Mar. 27. 2002 10:20AM SRMC SOSS

ELIMINATION

Bowel: ☒ No difficulty ☐ Constipation ☐ Diarrhea
Frequency of stool _____ Last BM _____
☐ Incontinence ☐ Ileostomy ☐ Colostomy
Comments: _____

Bladder: ☒ No difficulty ☐ Incontinence ☐ Hematuria
Frequency _____ Last Voiding _____
☐ Nocturia ☐ UTI ☐ Dribbling
☐ Catheter Type/Size _____ Date of insertion: _____
Comments: _____

ACTIVITY

Walking: ☒ No difficulty ☐ Stiffness ☐ Weakness
☐ Paralysis ☐ Frequent Falls ☐ Loss of Balance
☒ Contractures ☐ Deformities
☐ History of fractures _____

Upper Extremity: ☒ No difficulty ☐ Weakness ☐ Paralysis
☐ Deformities ☐ Splints ☐ Contractures

Functional:
(I=Independent D=Dependent N=Needs assistance)
Transfers I Bed mobility I Feeding I
Transportation I Toileting I Walking I
Hygiene I Housekeeping I Dressing I
Stairs I Cooking I Shopping I

Sexual/Reproductive

Self Breast Exam: ☐ Yes ☐ No Date of last Mammogram: _____
Use of Contraceptives: ☐ Yes ☐ No If yes, what type: _____ Date of LMP _____
Prostate Problems: ☐ Yes ☒ No If yes, what type: _____

Have you ever had a blood transfusion? ☐ Yes ☒ No If yes, when, month/year _____
Ever had an adverse reaction to blood? ☐ Yes ☐ No

History of seizure disorders ☒ No ☐ Yes Swallowing difficulty/choking ☒ No ☐ Yes
Change in Speech/communication abilities ☒ No ☐ Yes

Nutrition

Chewing/Swallowing difficulty ☒ No ☐ Yes _____
Poor appetite/intake (Greater than 3 days) ☒ No ☐ Yes _____
Vomiting (greater than 3 days) ☒ No ☐ Yes _____
Nutritional supplements (i.e. Ensure, MVI, herbals, high calorie/protein drinks) ☒ No ☐ Yes _____
Unintentional weight loss (+10 lbs. in 3 mos.) ☒ No ☐ Yes _____
Special dietary considerations (ex. Lactation, tube feeding) _____

New onset seizures ☐ Yes ☒ No New CVA ☐ Yes ☒ No Cancer ☐ Yes ☒ No HIV Positive ☐ Yes ☒ No

Acquired deficits during Hospitalization:
☐ Impaired vision
☐ Impaired speech

Factors that may affect learning/performing process:
Physical limitations: ☒ No ☐ Yes Cognitive limitations: ☒ No ☐ Yes
Language barriers: ☒ No ☐ Yes Psychosocial factors: ☒ No ☐ Yes

Fall Risk Assessment

Any check in this section requires placement on Fall Prevention Program:
☐ History of previous falls
☐ Altered mental status (confusion, disorientation, belligerent, combative)

Any checks in this section requires placement on Fall Prevention Program:
☐ Age 65 or over
☐ Urinary urgency or frequency; incontinent
☐ Bowel urgency or frequency; incontinent
☐ 1st 48 hours on diuretics, eye drops, tranquilizers, narcotics, analgesics, barbiturates, hypnotics, antidepressants
☐ Scheduled for bowel prep
☐ Sensory deficits
☐ Orthostatic hypotension: Syncope, vertigo, seizures
☐ Use of ambulatory devices (cane, walker, brace, splint)
☐ Activity intolerance (easily fatigued)

A. [illegible] PA
FCI [illegible], WI
Signature/Title _____ Date: 5/12/04

5-13-04
K.A. Laybourn, M.D.

Southside Regional Medical Center History and Physical Outpatient

Patient: Ward, Myron Physician:

Allergies No Known Drug Allergies

Present Complaint:

Past History:
- ____ Arrythmias
- ____ CAD
- ____ CHF
- ____ Diabetes
- ____ Hypertension
- ____ Hypokalemia (on diuretics)
- ____ PVD
- ____ Pulmonary Disease
- ____ Renal Disease
- ____ Anticoagulant Therapy
- ____ Cancer

Medications: None

PHYSICAL EXAM

General Condition Alerted, oriented [illegible]

Head/Neck Lymphadenopathy [illegible]

Heart +S1 S2 [illegible] S3 S4 [illegible]

Chest/Lungs clear, no rales, no [illegible]

Breast [illegible]

Abdomen Soft, no tender, no organomegaly, Bowel sound [illegible]

Genitalia/Pelvic [illegible]

Neurological [illegible]

Extremities [illegible]

Other exam pertinent to this admission

BP 115/57 T 97' P 57 R 18

Impression Neck Lymphadenopathy

Plan Biopsy of lymph node

A. Z[illegible], P.A. [signature]

Attending Physician's Signature Date [illegible]

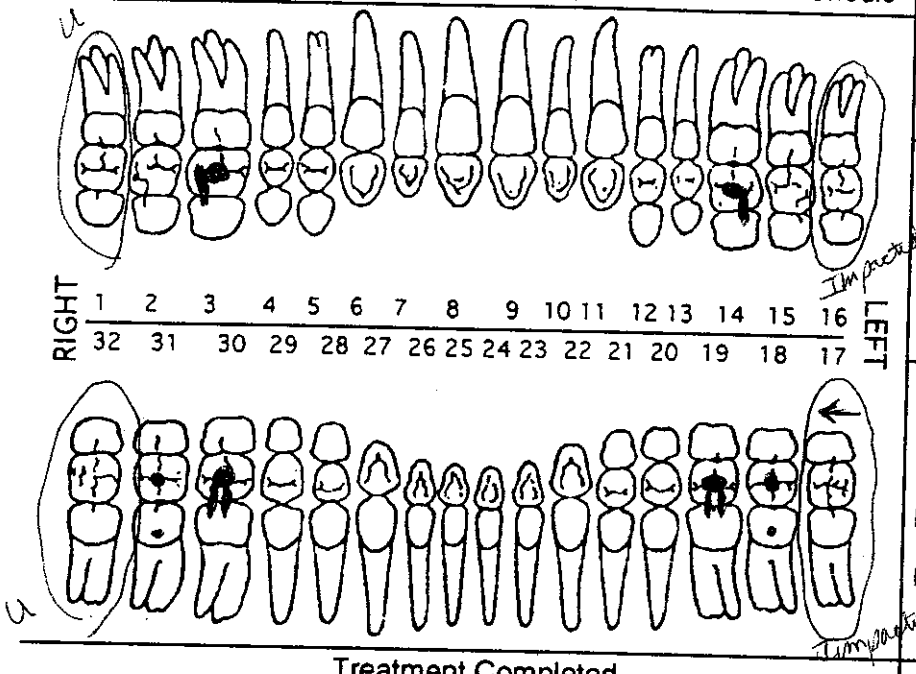
[initials] 5-13-04

K.A. Laybourn, M.D.

BP-S618.060 **CLINICAL DENTAL RECORD** CDFRM
AUG 96

U.S. DEPARTMENT OF JUSTICE **FEDERAL BUREAU OF PRISONS**

Examination: ☐ Screening ☑ Comprehensive ☐ Periodic



Occlusion Class I

Oral Hygiene Good Fair Poor

CPITN

2	2	2
3	2	3

Head & Neck/Soft Tissue

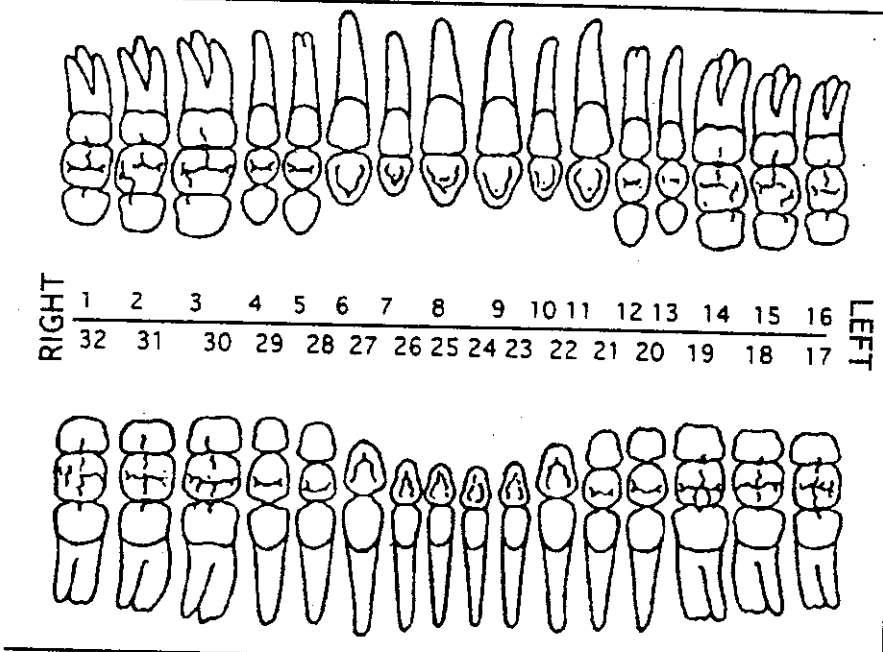
STWNL

Additional Findings

Vert crowding

D: 0
M: 0
F: 6

Treatment Completed



Recommended Treatment Plan

☒ Radiographs 4 BWx 2-5-03 WKC 2/5/03

☒ Dental Prophylaxis 12-17-02

☒ Oral Hygiene Instruction 12-17-02 / 2/5/03

☐ Periodontal Evaluation 0 I II III

☐ Oral Surgical Procedures

☐ Endodontic

☐ Restorative

☐ Prosthodontic Evaluation

Patient Name Number Sex: M F Age:

Ward, Myron 05967-084 32

Dentist Signature Date

12-17-02

FCI McKean

W.K. Collins, DDS
Chief Dental

Federal Bureau of Prisons Clinical Dental Records

Date/Time	#	Diagnosis - Treatment - Remarks
12-17-02		SOA: Routine Care patient
1230hrs		P: update medical hist, soft tissue exam, perio probe, scale. hand & ultrasonic scaler - oral hygiene instru.
		Next: 2/Bwx f/scale polish topical fluoride review brushing & Comp exam pr Dr Collins
		Jody L Batista RDH
		Jody L Batista RDH
		William K. Collins
		W.K. Collins, DDS Chief Dental
1-22-03		SOA: Routine care patient
1030hrs		P: tried to get him in for completion of prophy care - could not fend him in his unit will reschedule.
		Jody L Batista
		Jody L. Batista
		William K Collins RDH
		W.K. Collins, DDS Chief Dental
2-5-03		SOA: Routine care patient
		P: update health history, soft tissue Check 4 Bite wing x rays fore scale, oral hygiene review polish topical fluoride applied Jody L Batista RDH
		pt rinsed with 0.12% chlorhex prior to scale Jody L Batista RDH
		William K. Collins
		William K. Collins, D.D.S. CDO FCI McKean

FEDERAL BUREAU OF PRISONS
DENTAL/MEDICAL HEALTH HISTORY FORM

1. Are you currently taking any medication? If so, what? _____ yes (no)

2. Are you allergic to or have you had a reaction to any medication or drug? If so, what? _____ yes (no)

3. Have you been under the care of a physician during the past two years? If so, why? _____ yes (no)

4. Have you been hospitalized in the past two years? If so, why? _____ yes (no)

5. Do you have or have you ever had a heart murmur or been treated for a heart condition? yes (no)

6. Do your ankles ever swell during the day? yes (no)

7. Have you ever been treated for a tumor or growth? yes (no)

8. Have you ever had abnormal bleeding? yes (no)

9. Have you ever had serious difficulty with any dental treatment? yes (no)

10. Have you ever had clicking, popping, or pain in your jaw joint? yes (no)

Circle any of the following that you have had:

Congenital heart defects
Heart attack or heart problems
Stroke
Rheumatic Fever
Asthma
Anemia (blood problems)
Thyroid problems
Chronic bronchitis
Venereal disease (syphilis, gonorrhea)
Arthritis
Artificial heart valve
Hepatitis
Heart murmur
Angina
High Blood pressure
Heart pacemaker
Epilepsy or seizures
Diabetes
AIDS or HIV infection
Emphysema
Tuberculosis (TB)
Psychiatric treatment
Artificial joint

Do you currently use tobacco (cigarettes, chewing tobacco, snuff)? yes (no)

Do you have any disease, condition, or problem not listed? NO
WOMEN ONLY: Are you pregnant?

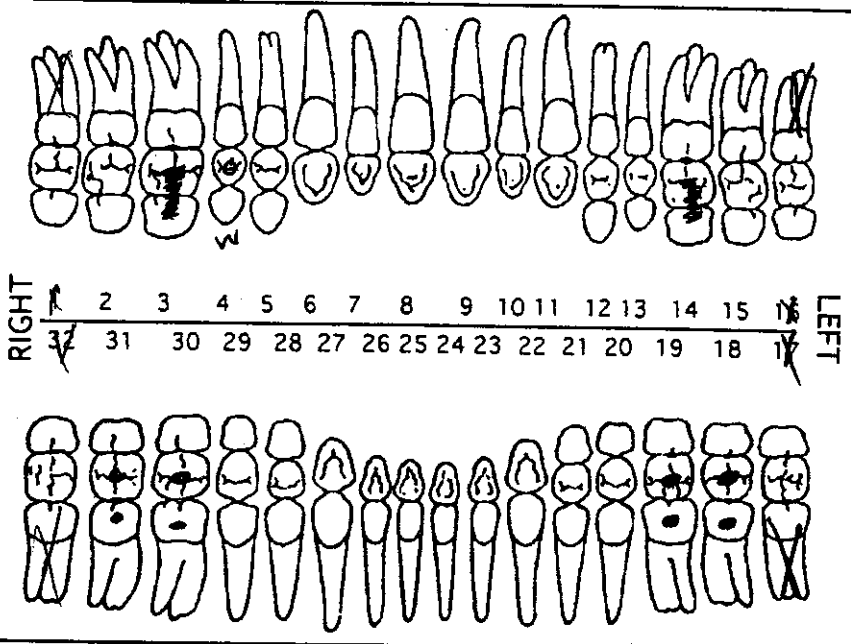
Name: WARD, MYRON Reg No. 05967-084

Institution: FCI McKean Date: 10/17/02

BP-S618.060 **CLINICAL DENTAL RECORD** CDFRM
AUG 96

U.S. DEPARTMENT OF JUSTICE **FEDERAL BUREAU OF PRISONS**

Examination: ☒ Screening ☐ Comprehensive ☐ Periodic



Occlusion: Class I

Oral Hygiene: (Good) Fair Poor

CPITN: 2 | 2 | 2 / 2 | 2 | 2

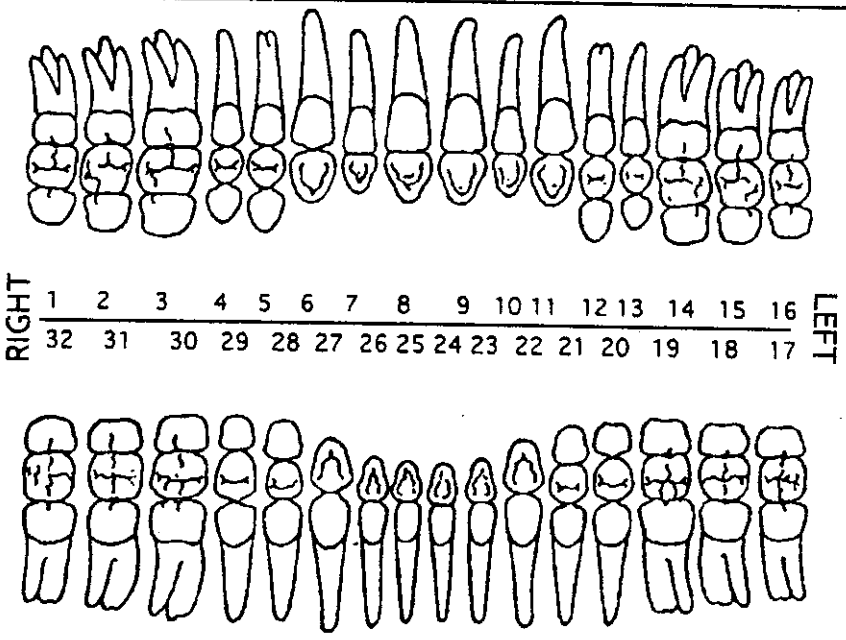
Head & Neck/Soft Tissue: WNL

Additional Findings

D: 0
M: 4
F: 6

Caries risk: low

Treatment Completed



Recommended Treatment Plan

- ☐ Radiographs
- ☐ Dental Prophylaxis
- ☐ Oral Hygiene Instruction
- ☐ Periodontal Evaluation 0 I II III
- ☐ Oral Surgical Procedures
- ☐ Endodontic
- ☐ Restorative
- ☐ Prosthodontic Evaluation

Patient Name: Ward, Myron
Number: 05967-084
Sex: M F
Age:

Dentist Signature: Dean Cohen DDS
Date: 5-25-99

Dean Cohen, DDS, CDO
FCI/FPC Cumberland

Federal Bureau of Prisons Clinical Dental Records

Date/Time	#	Diagnosis - Treatment - Remarks
05/25/99 0930		Dental Screening Examination, medical history, head & neck, soft tissue, periodontal and hard tissue examinations, charting performed. Patient was advised of the findings, recommendations and education on the reverse. OHI provided. Advised to request routine care by copout if desired. Written dental orientation information given.: DEAN COHEN, DDS FCI CUMBERLAND

FEDERAL BUREAU OF PRIS...
DENTAL MEDICAL HEALTH HISTORY FOR...

1. Are you currently taking any medication? yes (no)
   If so, what? _____

2. Are you allergic to or have you had a reaction to any medication or drug? If so, what? yes (no)
   _____

3. Have you been under the care of a physician during the past two years? If so, why? _____ yes (no)

4. Have you been hospitalized in the past two years? If so, why? _____ yes (no)

5. Do you have or have you ever had a heart murmur or been treated for a heart condition? yes (no)

6. Have you ever been treated for a tumor or growth? yes (no)

7. Have you ever had abnormal bleeding? yes (no)

8. Have you ever had serious difficulty with any dental treatment? yes (no)

Circle any of the following that you have had:

Congenital heart defects	Heart murmur	Heart attack or heart problems
Angina	Stroke	High Blood pressure
Rheumatic Fever	Heart pacemaker	Asthma
Epilepsy or seizures	Anemia (blood problems)	Diabetes
Thyroid problems	AIDS or HIV infection	Chronic bronchitis
Emphysema	Tuberculosis (TB)	Arthritis
Psychiatric treatment	Artificial heart valve	Artificial joint
Hepatitis	Painful jaw joint	Venereal disease (syphilis, gonorrhea)

Do you have any disease, condition, or problem not listed?

Do you currently use tobacco (cigarettes, chewing tobacco, snuff) yes (no)

Approximate time remaining on sentence (months): 19 yrs.

Name: WARD, MYRON Reg No. 05967084

Institution: **FCI / FPC Cumberland** Date: 5-25-99

CRL
OH I

4.9 A
5.9 A

MEDICAL REPORT OF DUTY STATUS

NAME: Ward, Myron

ADDRESS:

HOSPITAL REGISTRATION NO.: 05967-084

INPATIENT

INCLUSIVE DATES OF TREATMENT From: 10/2/10 Through: 10/3/10

OUTPATIENT

DATE: TIME ARRIVED: A.M./P.M. TIME DEPARTED: A.M./P.M.

DISPOSITION

Can resume usual occupation	DATE	Can perform limited duties as specified under REMARKS	DATE
To return to clinic	DATE	To be hospitalized	DATE
OTHER (Specify)			

REMARKS: restricted to unit except for meals & health services

NAME AND LOCATION OF HOSPITAL OR CLINIC	SIGNATURE OF MEDICAL OFFICER OR MEDICAL RECORD LIBRARIAN	DATE
FCI Cumberland	[signature] Physician Assistant	10/2/10

BS-131 (1/89)

Dk: 4

FEDERAL ... RECTIONAL INSTITUTION HO...PITAL
FCI Petersburg, VA 23804

DATE 5-20-04

IDLE, CONVALESCENT AND CHANGE IN WORK CLASSIFICATION STATUS

TO: ALL CONCERNED
INMATE'S NAME: Ward, Myron UNIT: Maryland Hall Detail: CCS Orderly
REG. NO.: 05967-084

For Medical purposes, the inmate named above has been authorized the work and/or activity status listed below for the reason(s) and the time shown.

MEDICAL CLASSIFICATION STATUS: (Check one and answer questions)

( ) IDLE: _____ THRU 12 MIDNIGHT _____, 19____

(✓) CONVALESCENCE: List any restricted activity for medical reasons. _____ THRU 12 MIDNIGHT 5-31, ~~19~~ 2004

( ) RESTRICTED DUTY: Specify exact restriction and reason. _____ THRU 12 MIDNIGHT _____, 19____

( ) MEDICAL UNASSIGNED

( ) BED REST

No sports
No rec yard

V. Pegram RN/V Pegram RN
Physician or Physician Assistant

DEFINITIONS AND INSTRUCTIONS

IDLE STATUS - Temporary disability not to exceed three days duration including weekends and holidays. Restricted to quarters except for meals, barbering, religious services, sick call, visits and call outs. No recreation activity.
CONVALESCENT STATUS - Recovery period for operation, injury, or serious illness. Not less than four days and not to exceed thirty days, subject to renewal. No work; no sports
RESTRICTED DUTY - Restricted from work around machinery, heights, heavy lifting, etc., because of physical or mental handicap. List handicap, work limitation and time period, either specific date or indefinite.
Medical Unassgn - Totally unemployable and unassigned because of mental or physical reasons.

White copy – Hospital Yellow copy – Detail Officer Pink copy – Inmate Gold copy – File

FE... CORRECTIONAL INSTITUTION
FCI Petersburg, Petersburg, VA 23804

DATE: 12/3/03

IDLE, CONVALESCENT AND CHANGE IN WORK CLASSIFICATION STATUS

TO: ALL CONCERNED
INMATE'S NAME: Ward, Myron UNIT: Med DETAIL: CCS Orderly
REG. NO.: 05967-084

For Medical purposes, the inmate named above has been authorized the work and/or activity status listed below the reason(s) and the time shown.

MEDICAL CLASSIFICATION STATUS: (Check One and answer questions)

( ) IDLE: Reason _____ THRU 12 MIDNIGHT _____, 20____

( ) CONVALESCENT: List any restricted activity for medical reasons. _____ THRU 12 MIDNIGHT _____, 20____

(X) RESTRICTED DUTY: Specify exact restriction and reason. No work around machinery / No ladder / No work around chemical equipment THRU 12 MIDNIGHT _____, 20____

( ) MEDICAL UNASSIGNED:

( ) BED REST: Pending Optometrist Evaluation on 3/3/04

V. Peneguitan, NLP
FCC Petersburg, Va
Physician or Physician Assistant

DEFINITIONS AND INSTRUCTIONS

IDLE STATUS - Temporary disability not to exceed three days duration including weekends and holidays. Restricted to quarters except for meals, barbering, religious services, sick call, visits and call outs. No recreation activity.
CONVALESCENT STATUS - Recovery period for operation, injury, or serious illness. Not less than four days and not to exceed thirty days, subject to renewal. No work and no sports.
RESTRICTED DUTY - Restricted from work around machinery, heights, heavy lifting, etc., because of physical or mental handicap. List handicap, work limitation and time period, either specific date or indefinite.
MEDICAL UNASSIGNED: - Totally unemployable and unassigned because of mental or physical reasons.

INMATE REQUEST TO STAFF RESPONSE
INMATE: Ward, Myron
REGISTER NO.: 05967-084

This is in response to your Inmate Request to Staff, dated April 19, 2005, in which you request information pertaining your ENT referral.

Investigation reveals there is a current referral for an ENT evaluation on file, dated April 19, 2005. This evaluation is done off site and is scheduled based on availability. If you are experiencing pain or discomfort, you should report to sick call for further evaluation.

C. A. Mendoza, HSA

5-19-05
Date

TO: (Name and Title of Staff Member)	DATE:
Mendoza H.A.	4/19/05
FROM:	REGISTER NO.:
Ward, Myron	05967-084
WORK ASSIGNMENT:	UNIT:
CCS, ORD.	Maryland

SUBJECT: (Briefly state your question or concern and the solution you are requesting. Continue on back, if necessary. Your failure to be specific may result in no action being taken. If necessary, you will be interviewed in order to successfully respond to your request.)

Last November I was recommended to see the "ENT". I would like to know if I am still on the list since I have not seen him/her yet.

Thank you

(Do not write below this line)

DISPOSITION:

See attached

Signature Staff Member	Date

Record Copy - File; Copy - Inmate
(This form may be replicated via WP)

This form replaces BP-148.070 dated Oct 86 and BP-S148.070 APR 94

513-111

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD

CONSULTATION SHEET

REQUEST

TO: ENT Otolaryngology

FROM: (Requesting physician or activity) Medical

DATE OF REQUEST 2/7/06

REASON FOR REQUEST (Complaints and findings)

38y/o BM seen in the past per notes, limited, has hyperemesis today

PROVISIONAL DIAGNOSIS

DOCTOR'S SIGNATURE [illegible], MLP

APPROVED

PLACE OF CONSULTATION ☐ BEDSIDE ☐ ON CALL

☐ ROUTINE ☐ TODAY ☐ 72 HOURS ☐ EMERGENCY

CONSULTATION REPORT

RECORD REVIEWED ☐ YES ☐ NO

PATIENT EXAMINED ☐ YES ☐ NO

TELEMEDICINE ☐ YES ☐ NO

(Continue on reverse side)

SIGNATURE AND TITLE

DATE

HOSPITAL OR MEDICAL FACILITY

RECORDS MAINTAINED AT

DEPARTMENT/SERVICE OF PATIENT

RELATION TO SPONSOR

SPONSOR'S NAME (Last, first, middle)

SPONSOR'S ID NUMBER (SSN or Other)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name--last, first, middle; ID no. (SSN or other); Sex; Date of Birth: Rank/Grade)

Mann, Wayne

REGISTER NO.

WARD NO.

Health Services Unit-Low
FCC Petersburg, VA

HEALTH SERVICES UNIT-LOW
FCC PETERSBURG, VA

CONSULTATION SHEET
Medical Record

STANDARD FORM 513 (REV. 4-98)
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11 .203(b)(10)

U.S. DEPARTMENT OF JUSTICE FEDERAL BUREAU OF PRISONS

TO: (Name and Title of Staff Member)	DATE:
Dr. LaBourne	4/19/05
FROM:	REGISTER NO.:
Ward, Myron	05967-084
WORK ASSIGNMENT:	UNIT:
CCS, ORD	Maryland

SUBJECT: (Briefly state your question or concern and the solution you are requesting. Continue on back, if necessary. Your failure to be specific may result in no action being taken. If necessary, you will be interviewed in order to successfully respond to your request.)

It was recommended that I see the ENT. This was last November and I have not seen him/her yet. I would like to know if I am still on the list.

Thank you

(Do not write below this line)

DISPOSITION:

you were seen by ENT in 3/10/04 and the only recommendations were to continue nasal spray. No surgery recommended. No Follow up needed by ENT

Signature Staff Member	Date
K A Laylord	5/16/05

Record Copy - File; Copy - Inmate
(This form may be replicated via WP)

This form replaces BP-148.070 dated Oct 86 and BP-S148.070 APR 94

FEDERAL BUREAU OF PRISONS

TO: (Name and Title of Staff Member)
Medical (Surgeon)

DATE:
12/31/03

FROM:
Ward, Myron

REGISTER NO.:
05967-084

WORK ASSIGNMENT:
CCS (ORD.)

UNIT:
Maryland

SUBJECT: (Briefly state your question or concern and the solution you are requesting. Continue on back, if necessary. Your failure to be specific may result in no action being taken. If necessary, you will be interviewed in order to successfully respond to your request.)

I am told that I am on the list to see the Surgeon about some lumps on the right side of my neck. I have now notice a little lump on the left side of my neck. I would like to know what number I am on the list or if I will be seen soon

Thank you

(Do not write below this line)

DISPOSITION:

you were seen 1-14-04.

Signature Staff Member:

Date:
4-2-04

Record Copy - File; Copy - Inmate

Replaces BP-148 of OCT 86

MEDICAL DUTY STATUS (MDS)

( ) REG DUTY
(✓) REG DUTY W
( ) NOT MED CLEARED
( ) WGT; 15, 20, 25 LBS
( ) STAND RSTR
( ) HEAR RESTR
( ) NO POLLUT
( ) NO F/S
( ) ART LIMB
( ) NO DRIVING
) DRIV REST
( ) BED BOARD
( ) LOWER BUNK
( ) ORTH SHOES
( ) SOFT SHOES
( ) SMOKE FREE

( ) NO DUTY
( ) OTHER; specify _____

( ) ATH RESTR
( ) LIMIT SUN
( ) COLD / WIND
(✓) HGT RESTR
(✓) YES F/S
( ) ALLRG/WOOL

CARE LEVEL I

PHYSICAL EXAMINATION LIST
( ) UNDER 50 - PE due : _____
( ) OVER 50 - PE due: _____

TB TESTING/FOLLOW UP (WLS CODES)
( ) PPY -- POSITIVE PPD; YEARLY CXR due: _____
(✓) NPY -- NEGATIVE PPD; PPD RETEST due: 2/10/04

DISABILITY ASSIGNMENT (SEE O.M. 256-93 FOR DEFINATION)
For every entry in group1, you must have an entry in Group IIA and IIB or group III.
(Ex DISF-ACC U or DISF-NO AC)

Group I.
DISF -- Disfigurement
EXRT -- Missing Extremity
HEAR -- Hearing Disability
ORTH -- Orthopedic Disability
PPAR -- Partial Paralysis
PHYS -- Other Phys. Disability
SPCH -- Speech Disability
TPAR -- Total Paralysis

GROUP II.
ACC -- Architectural Mod. For Access
ARF -- Archit. Mod. To assist Mobility
COM - Communication Assistance
MOB - Accom. For Equip to assist Mobilty
EQF -- Accom. For Equip to assist Function
ACT -- Other Assist. In Job Assign, or Activities
PGM -- Other Programs
WCH - Wheelchair

GROUP IIB
U -- Unsatisfied Needs for Accomodation
N -- Required Addition of Accomodation To satify needs
P -- Needs were satified by a pre-existing Accomodation

GROUP III
No ACC -- No Accomodation Required

INMATE NAME: Ward, Myron
REG NUMBER: 05967-084

PA SIGNATURE _____ E. Pennington, MD

SEP 98

INMATE REQUEST TO STAFF MEMBER

U.S. DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF PRISONS

TO: (Name and Title of Staff Member)	DATE:
Medical	12/1/03
FROM:	REGISTER NO.:
WARD, Myron	05967-084
WORK ASSIGNMENT:	UNIT:
CCS Ord.	Maryland Hall

SUBJECT: (Briefly state your question or concern and the solution you are requesting. Continue on back, if necessary. Your failure to be specific may result in no action being taken. If necessary, you will be interviewed in order to successfully respond to your request.)

It has been more than two years since my last physical. If possible I would like to be scheduled for one.

Thank you

(Do not write below this line)

DISPOSITION:

Lab + physical are scheduled for 12/3/03 at 8:00 AM

Signature Staff Member:	Date:
MSWard	12-1-03

Record Copy - File; Copy - Inmate

Replaces BP-148 of OCT 86

BP-A148.070
SEP 88

INMATE REQUE / STAFF MEMBER

U.S. DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF PRISONS

TO: (Name and Title of Staff Member)	DATE:
Medical Records	11/7/03
FROM:	REGISTER NO.:
Ward, Myron	05967-084
WORK ASSIGNMENT:	UNIT:
unassigned	Maryland

SUBJECT: (Briefly state your question or concern and the solution you are requesting. Continue on back, if necessary. Your failure to be specific may result in no action being taken. If necessary, you will be interviewed in order to successfully respond to your request.)

I would like a copy of my medical records From July 1, 2003 through the Present.

Thank you

(Do not write below this line)

DISPOSITION:

Records Copied.

Signature Staff Member:	Date:
T. Wilson	11/17/03

Record Copy - File; Copy - Inmate

Replaces BP-148 of OCT 86

FCI McKean
Inmate Sick Call Sign-Up Sheet
(Formulario y Registro para Atencion Medica de Confinados)

INSTRUCTIONS
You must fill out this form completely, numbers 1-9:
(Debe de llanar este formulario completamente, numeros 1-9.)

1. Name: WARD Myron
(Nombre)
2. Reg. Number: 05967-084
(Numero de Registro)
3. Date: 6/10/03
(Fecha)
4. Housing unit and Unit Team: C/B TEAM: A B (C) D
(unidad y equipo de la unidad)
5. Complaint, What is your problem?
(Queja). (Cual es su problema?)
I would like my medical records from the period of February 2002 through October 2002. Thank you
(and June 5, 2003 – present)
6. How long have you had this problem?
(Durante cuante tiempo ha tenido este problema?)
Days _____ Months _____ Years _____
(Dias) (Meses) (Anos)
See Attached
7. Are you on any medication(s) at present? Yes _____ No _____
(Esta usted tomando alguna(s) medicinas actualmente?)
8. Have you purchased Over-the-Counter Medications from Commissary?
(Ha comprado medicinas non-prescipcion en la Comisaria?)
Yes _____ No _____
9. Signature Myron Ward
(Firma)

TO BE COMPLETED BY HEALTHCARE STAFF TRIAGE PERSONNEL:

10. Date seen: _____
11. Time seen: _____
12. Subjective: _____
_____
_____
13. Objective: Temp: _____ Pulse _____ Respirations _____ B/P _____
14. Appointment Date: _____ Appointment Time _____
15. Triage Personnel's Signature: _____

BP-S148.055 INMATE REQUEST TO STAFF CDFPM
SEP 98
U.S. DEPARTMENT OF JUSTICE — FEDERAL BUREAU OF PRISONS

TO: (Name and Title of Staff Member) Medical Records	DATE: 5/30/03
FROM: WARD, Myron	REGISTER NO.: 05967-084
WORK ASSIGNMENT: Unicor/Night	UNIT: C/B

SUBJECT: (Briefly state your question or concern and the solution you are requesting. Continue on back, if necessary. Your failure to be specific may result in no action being taken. If necessary, you will be interviewed in order to successfully respond to your request.)

If possible, I would like a copy of my medical records from April 2003 to the present.

Thank You

(Do not write below this line)

DISPOSITION:

See Attached
3 pgs

FCI McKean

Signature Staff Member

Date 6/2/03

Record Copy - File; Copy - Inmate
(This form may be replicated via WP)

This form replaces BP-148.071 dated Oct 86 and BP-S148.070 APR 94

BP-S148.070 INMATE REQUEST TO STAFF MEMBER CDFRM
APR 94
UNITED STATES DEPARTMENT OF JUSTICE FEDERAL BUREAU OF PRISONS

DATE 4/15/03

TO: Medical Records
(Name and Title of Officer)

SUBJECT: State completely but briefly the problem on which you desire assistance and what you think should be done (Give details).

If possible I would like my medical records from February 2003 to the present

Thank you

(Use other side of page if more space is needed)

NAME: WARD, MYRON NO: 05967-084

WORK ASSIGNMENT: Unicor/Assembly UNIT: C/B

NOTE: If you follow instructions in preparing your request, it can be disposed of more promptly and intelligently. You will be interviewed, if necessary, in order to satisfactorily handle your request. Your failure to specifically state your problem may result in no action being taken.

DISPOSITION: (Do not write in this space)

DATE 4-16-03

See Attached 3pgs

FCI McKean

Officer

Record Copy - File; Copy - Inmate

BP-S148.070 INMATE REQUEST TO STAFF MEMBER CDFRM
APR 94
UNITED STATES DEPARTMENT OF JUSTICE FEDERAL BUREAU OF PRISONS

DATE 11/18/02

TO: Dental Hygenist
(Name and Title of Officer)

SUBJECT: State completely but briefly the problem on which you desire assistance and what you think should be done (Give details).

I have noticed that I am number 5 on the Dental list. Is there a certain day I should come in or will my name be on the call out?

(Use other side of page if more space is needed)

NAME: WARD, MYRON NO: 05967-084

WORK ASSIGNMENT: Unicor (Assembly 2) UNIT: CB

NOTE: If you follow instructions in preparing your request, it can be disposed of more promptly and intelligently. You will be interviewed, if necessary, in order to satisfactorily handle your request. Your failure to specifically state your problem may result in no action being taken.

DISPOSITION: (Do not write in this space)

DATE 11/21/02

Please continue to watch the call outs. It will be soon for your V-up.

J. Batista

Record Copy - File; Copy - Inmate

FCI McKean

Inmate Sick Call Sign-Up Sheet

(Formulario y Registro para Atencion Medica de Confinados)

02 OCT 35 PM 11:21 HEALTH SVC.

INSTRUCTIONS:

You must fill out this form completely, numbers 1-9:
(Debe de llanar este formulario completamente, numeros 1-9.)

1. Name: (Nombre) WARD, Myron
2. Reg. Number: (Numero de Registro) 05967-084
3. Date: (Fecha) 11/4/02
4. Housing unit and Unit Team: (Unidad y equipo de la unidad) CB TEAM: A B (C) D
5. Complaint. What is your problem ? (Queja). (Cual es su problema?)
   I have a rash all over my back & the medication given doesn't seem to be working
6. How long have you had this problem?
   (Durante cuante tiempo ha tenido este problema?)
   Days (Dias)_____ Months (Meses)_____ Years (Anos) X
7. Are you on any medication(s) at present? Yes_____ No X
   (Esta usted tomando alguna(s) medicinas actualmente?)
8. Have you purchased Over-the-Counter Medications from Commissary?
   (Ha comprado medicinas non-prescipcion en la Comisaria?
   Yes_____ No X
9. Signature (Firma) Myron Ward

TO BE COMPLETED BY HEALTHCARE STAFF TRIAGE PERSONNEL:

10. Date Seen:_____
11. Time Seen:_____
12. Subjective:_____
13. Objective: Temp._____ Pulse_____ Respirations_____ B/P_____
13. Appointment Date:_____ Appointment Time_____
14. Triage Personnel's Signature:_____

FCI McKean

Inmate Sick Call Sign-Up Sheet

(Formulario y Registro para Atencion Medica de Confinados)

02 OCT 35 PM 11:20

INSTRUCTIONS:

You must fill out this form completely, numbers 1-9:
(Debe de llanar este formulario completamente, numeros 1-9.)

1. Name: (Nombre) WARD, Myron
2. Reg. Number: (Numero de Registro) 05967-084
3. Date: (Fecha) 11/4/02
4. Housing unit and Unit Team: (Unidad y equipo de la unidad) C B TEAM: A B (C) D
5. Complaint. What is your problem ? (Queja). (Cual es su problema?)
   If possible, I would like a refill of the Dibucaine ointment for my hemmeroid problem
6. How long have you had this problem? (Durante cuante tiempo ha tenido este problema?)
   Days (Dias)_____ Months (Meses)_____ Years (Anos) X
7. Are you on any medication(s) at present? Yes_____ No X
   (Esta usted tomando alguna(s) medicinas actualmente?)
8. Have you purchased Over-the-Counter Medications from Commissary? (Ha comprado medicinas non-prescipcion en la Comisaria?
   Yes_____ No X
9. Signature (Firma) Myron Ward

TO BE COMPLETED BY HEALTHCARE STAFF TRIAGE PERSONNEL:

10. Date Seen:_____
11. Time Seen:_____
12. Subjective:_____
13. Objective: Temp._____ Pulse_____ Respirations_____ B/P_____
13. Appointment Date:_____ Appointment Time_____
14. Triage Personnel's Signature:_____

Go to the Pharmacy on Thursday, 7 Nov 02 at 11:30 to pick up a new prescription for Debucaine

S. Labrozzi
Steven Labrozzi, PA-C
Physician Assistant

BP-S148.055 **INMATE REQUEST TO STAFF** CDFRM
SEP 98

U.S. DEPARTMENT OF JUSTICE **FEDERAL BUREAU OF PRISONS**

TO: (Name and Title of Staff Member) Dr. OLSON Medical	DATE: 9/21/01
FROM: WARD, MYRON	REGISTER NO.: 05967-084
WORK ASSIGNMENT: CMS/Landscape	UNIT: C/B

SUBJECT: (Briefly state your question or concern and the solution you are requesting. Continue on back, if necessary. Your failure to be specific may result in no action being taken. If necessary, you will be interviewed in order to successfully respond to your request.)

IF possible, I would like to discuss the medication I was given for hemorrhoids, and any other info or pamphlets on the subject. I would also like to discuss the possibility of having the operation to remove them.

Thank You

(Do not write below this line)

DISPOSITION:

Please Make a sick call appointment so you can be re-evaluated. I can be consulted at that time.

FCI McKean

Signature Staff Member
D. Olson, MD
Clinical Director

Date 9/24/01

Record Copy - File; Copy - Inmate
(This form may be replicated via WP)

This form replaces BP-148.070 dated Oct 86 and BP-S148.070 APR 94

Printed on Recycled Paper

BP-S148.055 **INMATE REQUEST TO STAFF** CDFRM
SEP 98

U.S. DEPARTMENT OF JUSTICE **FEDERAL BUREAU OF PRISONS**

TO: (Name and Title of Staff Member)	DATE:
Nurse "D" Team	3/20/01
FROM:	REGISTER NO.:
WARD, MYRON	05967-084
WORK ASSIGNMENT:	UNIT:
Unicor shop II	Central-TWO

SUBJECT: (Briefly state your question or concern and the solution you are requesting. Continue on back, if necessary. Your failure to be specific may result in no action being taken. If necessary, you will be interviewed in order to successfully respond to your request.)

My Face and back is breaking out. I may need some type of lotion or Cream if possible.

Thank You

(Do not write below this line)

DISPOSITION:

Appointment 3/22/01. See Callout.

Signature Staff Member	Date
[signature]	3/21/01

Record Copy - File; Copy - Inmate
(This form may be replicated via WP)

This form replaces BP-148.070 dated Oct 86 and BP-S148.070 APR 94

Printed on Recycled Paper

U.S. DEPARTMENT OF JUSTICE
Federal Bureau of Prisons

INMATE REQUEST TO STAFF MEMBER

DATE 2/20/00

TO: "D" TEAM PA
(Name and title of officer)

SUBJECT: State completely but briefly the problem on which you desire assistance, and what you think should be done (Give details).

I AM in need OF some hemroid medication

Thank You

(Use other side of page if more space is needed)

NAME: WARD, MYRON No.: 05967-084

Work assignment: UNICOR Unit: Central-Two

NOTE: If you follow instructions in preparing your request, it can be disposed of more promptly and intelligently. You will be interviewed, if necessary, in order to satisfactorily handle your request. Your failure to specifically state your problem may result in no action being taken.

DISPOSITION: (Do not write in this space) DATE

Officer

Original - File
Canary - Inmate

BP-S148.055 **INMATE REQUEST TO STAFF** CDFRM
SEP 98

U.S. DEPARTMENT OF JUSTICE **FEDERAL BUREAU OF PRISONS**

TO: (Name and Title of Staff Member)	DATE:
Medical PA-'D' TEAM	1/28/00
FROM:	REGISTER NO.:
WARD, Myron	05967-084
WORK ASSIGNMENT:	UNIT:
~~[illegible]~~ UnAssigned	central-Two

SUBJECT: (Briefly state your question or concern and the solution you are requesting. Continue on back, if necessary. Your failure to be specific may result in no action being taken. If necessary, you will be interviewed in order to successfully respond to your request.)

I have a case of athelets foot and am in need of medication

Thank you

(Do not write below this line)

DISPOSITION:

Signature Staff Member	Date

Record Copy - File; Copy - Inmate
(This form may be replicated via WP)

This form replaces BP-148.070 dated Oct 86 and BP-S148.070 APR 94

Printed on Recycled Paper

BP-S148.055 **INMATE REQUEST TO STAFF** CDFRM
SEP 98

U.S. DEPARTMENT OF JUSTICE **FEDERAL BUREAU OF PRISONS**

TO: (Name and Title of Staff Member) Dental	DATE: 1/28/00
FROM: WARD, Myron	REGISTER NO.: 05967-084
WORK ASSIGNMENT: Unassigned	UNIT: Central-Two

SUBJECT: (Briefly state your question or concern and the solution you are requesting. Continue on back, if necessary. Your failure to be specific may result in no action being taken. If necessary, you will be interviewed in order to successfully respond to your request.)

I would like my name added to the list for teeth cleaning

Thank You

(Do not write below this line)

DISPOSITION:

You have been placed on the Dental Waiting List. Please watch the call-out sheet.

#493

Signature Staff Member

Date 02-02-01

Record Copy - File; Copy - Inmate
(This form may be replicated via WP)

Melissa Westrick, RDH
Dental Assistant/Hygienist

This form replaces BP-148.070 dated Oct 86 and BP-S148.070 APR 94

Printed on Recycled Paper

BP-S148.055 **INMATE REQUEST TO STAFF** CDFRM
SEP 98

U.S. DEPARTMENT OF JUSTICE **FEDERAL BUREAU OF PRISONS**

TO: (Name and Title of Staff Member)	DATE:
Medical	1/11/01
FROM:	REGISTER NO.:
WARD, Myron	05967-084
WORK ASSIGNMENT:	UNIT:
A&O	Central-two "D" Team

SUBJECT: (Briefly state your question or concern and the solution you are requesting. Continue on back, if necessary. Your failure to be specific may result in no action being taken. If necessary, you will be interviewed in order to successfully respond to your request.)

I have a Fungus on my toes that I believe needs to be looked at.

Thank you

(Do not write below this line)

DISPOSITION:

Signature Staff Member	Date

Record Copy - File; Copy - Inmate
(This form may be replicated via WP)

This form replaces BP-148.070 dated Oct 86 and BP-S148.070 APR 94

Printed on Recycled Paper

FEDERAL CORRECTIONAL INSTITUTION CUMBERLAND
14601 BURBRIDGE ROAD S.E.
CUMBERLAND, MARYLAND 21502

I, the undersigned, have received my prescription eyeglasses as perscribed By the Medical Staff at FCI Cumberland.

Ward
Print name

Myra Ward
Signature

05967-084
Number

7-19-06
Date

McCusker
Staff Witness

DATE 5-25-99

TO: Dental Clinic
(Name and title of officer)

SUBJECT: State completely but briefly the problem on which you desire assistance, and what you think should be done (Give details).

I would like to have my teeth & Gums cleaned

Thank you

(Use other side of page if more space is needed)

NAME: Ward, Myron No.: 05967084

Work assignment: unassigned Unit: C-1

NOTE: If you follow instructions in preparing your request, it can be disposed of more promptly and intelligently. You will be interviewed, if necessary, in order to satisfactorily handle your request. Your failure to specifically state your problem may result in no action being taken.

DISPOSITION: (Do not write in this space) DATE 6-1-99

YOUR NAME HAS BEEN PLACED
ON THE DENTAL TREATMENT LIST.
PLEASE WATCH FOR YOUR CALL OUT.

Cohen DDS
Officer

Original - File
Canary - Inmate